BLOGGER'S ROUNDTABLE WITH LIEUTENANT COLONEL JASON WIEMANN, MD, DIVISION SURGEON, MULTI-NATIONAL DIVISION-BAGHDAD

SUBJECT: DOD'S NEW COMBAT LIFESAVER COURSE

MODERATOR: JACK HOLT, PUBLIC AFFAIRS SPECIALIST, OFFICE OF THE SECRETARY OF DEFENSE

TIME: 2:00 P.M. EDT
DATE: THURSDAY, APRIL 19, 2007

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COL. WIEMANN: Hello?

MR HOLT: Hello, Colonel Weimann?

COL. WIEMANN: Yes, sir.

MR. HOLT: Yes, sir.

COL. WIEMANN: How are you doing?

MR. HOLT: I'm doing well. Jack Holt here with The Blogger's Roundtable -- with OSD, and we've got a few folks on the line: Mark Finkelstein, Tom Baker and Strife. And we will, with that, begin -- and I'll just turn it over to you, sir.

COL. WIEMANN: Thank you, sir.

Hi -- hello, sir. My name's Jason Weimann, I'm a medical doctor with the Army. I was asked to give you a background of my training, I guess. I'm a family practitioner by trade -- that's what my residency and board certification are in. I also did a residency and board certification in Preventive Medicine and I have a master's degree in Epidemiology.

(Phone beeps.)

MR. : Hello?

MR. HOLT: Hello Charlie. No -- all right, Charlie, thanks for joining us.

Colonel, if you would continue.

COL. WIEMANN: Okay. I'm currently the division surgeon for the 1st Cavalry Division and I've been assigned to be the division surgeon for the Multinational Division -- Baghdad. I was asked to give you an overview of how our medical care for trauma scenarios is going. And the mainstay of this is a new program that we've come up with called the "Combat Lifesaver Course." It was changed dramatically in October of 2005 to add skills to nonmedical soldiers based on the injury patterns that we've been seeing during this conflict. And we've added several fairly advanced medical procedures to the repertoire of the nonmedical soldier. And many infantrymen and other combat-armed soldiers are receiving this fairly advanced medical training.

We based this on a lot of facts, but a lot of it goes back to the observation that, during the Vietnam conflict, a very large number of deaths occurred from people bleeding to death from extremity wounds, where it takes very little effort, really, to stop the bleeding coming out of an arm or a leg -- yet for some reason, this didn't happen and they saw a lot of deaths occurring. There were -- there are a few other injuries that are also very high on the list, to include something called a "tension pneumothorax," in which air is traumatically inserted into the chest cavity and proceeds to cause problems. And also, that a patient's airway is obstructed in some other way following an injury out in the field.

So with those three common injuries in mind, they developed this program called the Improved Combat Lifesaver Course. So we took nonmedical soldiers and we taught them decision-making skills for treating casualties when they're under fire, when they're

not under fire, and during evacuation process. And we taught them to use a variety of different emergency trauma dressings. In particular, the one we're using is called an "Israeli bandage" -- which is a simple pressure bandage that has a device that allows it to be pulled down in a pulley-like fashion to almost become a tourniquet. It provides a great deal of pressure directly to the wound and is enough, in most cases, to stop the bleeding.

Moving down the algorithm of what we teach, next comes the tourniquet. Now the tourniquet used to be considered a last-ditch effort in the treatment of casualties, but what we found is that limbs do quite well without blood for an extended period of time. During a lot of orthopedic surgeries, it's common to apply a tourniquet to a limb for up to two hours while the surgery's going on. So it became apparent that the application of a tourniquet was a safe thing to do for short periods of time. So we've developed something called a "combat application tourniquet," which can be applied with one hand -- meaning a soldier could apply it to himself for a limb wound as well. And that's a very common thing applied in the field in trauma.

Additionally, the combat lifesavers are taught to insert a nasal airway -- we call this a "nasal pharyngeal trumpet." It's a long tube that goes up the nose, down the back of the throat, into the trachea to prevent the airway from being obstructed during evacuation and other traumatic events that are happening in the field.

Next along that, in the event of this pneumothorax that I was talking about before, a common practice in a trauma center would be to insert a large-bore needle between the second and third rib and go into the pleural space where this air would be trapped and relieve that air from causing problems with the lung expansion. This has always been considered a very high-speed and advanced medical skill, and a lot of -- many physicians have never done even one. And we started teaching these to combat armed soldiers in the field, and on many occasions they have been placed and likely saved soldiers' lives.

In addition to these procedures, the soldiers are also taught on how to use a variety of litters and evacuation materials, to include the skid litter and just kind of a -- looks like a plastic sled that they wrap around the patients, and it gives them a fair amount of stability and they can be carried or dragged in that fashion.

And in addition to this training that the combat lifesavers get, we've -- as an army, as a whole, have issued out something called a "hemostatic dressing," or a "Chitosan" dressing. The chemical basis for this is a lobster shell derivative, which combines with blood to create an almost instantaneous clot. And one of these dressings are in each soldiers individual first-aid kit and can be used to directly stop arterial bleeding, which previously has been very difficult to manage in the field -- but with this advanced technology, we're often able to get this bleeding to stop without the aid -- or prior to getting to a surgeon.

When we've taken all these skills and we've coupled them with the fact that the air mobile evacuation assets within theater have never been paralleled in the history of

warfare. We can generally have a helicopter or two at a site in less than 15 or 20 minutes, and often have a patient to an advanced surgeon within 30 minutes to an hour after an injury. And we're seeing soldiers surviving wounds that, heretofore, would have been lucky to survive if they happened right next to a major trauma center.

So there's a real quick overview of anything. I'll open the floor for questions if anybody's got any.

Q Lieutenant Colonel, it's Mark Finkelstein from Newsbusters.

When I was out in al-Anbar in November, I had the chance to meet a number of Navy corpsmen and was very impressed with them and their training. How would you compare the level of training under this new program to that of the Navy corpsmen or an Army medic? And how would you expect these newly trained people to, sort of, augment the work of the corpsmen and medics?

COL. WIEMANN: That's a fantastic question. The Navy corpsmen that you're talking about is called "an independent-duty corpsman," and they do receive quite a bit more training than an Army medic would receive. As the name would imply, they are trained with the intent that they serve as the sole health care provider for a unit. You'll often find a Navy independent-duty corpsman being the sole medical care provider aboard a small ship like a frigate.

They're not quite to the level of a physician's assistant or a nurse practitioner, but they're fairly close. They do -- they can prescribe medications and do actual diagnostic procedures on patients. They can almost be considered a true health care provider.

The Army medic does receive quite a bit more training than the combat lifesaver does. They have a long additional -- or additional individual training course that they go to. The Army medic in today's world is a certified paramedic when they finish their medical training, as part of their Army training. But they are actually licensed paramedics when they're finished with their training.

The combat lifesaver was a concept born purely from looking at those types of injuries that should have been survivable, but often cause death -- and focusing medical training on those individual skills. But the combat lifesaver, generally, doesn't have any of the medical background involving making diagnoses, but he's been taught these critical techniques to relieve these injuries before they cause death.

So that would be the order they'd go in, and order of capabilities. The Navy independent-duty corpsman would be more capable than an Army medic. An Army medic, in turn, is much more capable than he used to be -- he's now a certified EMT and he would be considerably more trained than a combat lifesaver. And the combat lifesaver's goal is simply to keep his buddy alive until we can get him to a higher level of care -- usually a combat support hospital where surgeons are present.

Q That's interesting -- I was not aware that there was a difference in level of training between Army medics and Navy corpsmen.

Quick follow up. I know that the survival rates in the Iraq war are historically higher than in any previous conflict -- can you talk a little bit about that?

COL. WIEMANN: Yes, they're extremely high, exceeding 98 percent of injuries. And, in light of the very traumatic nature of the injuries that are being seen here, that's quite impressive. And a lot of these are due to the combat lifesavers. We've seen some truly horrendous wounds that we would have never expected survival from, which, in turn did survive, just with the help of the combat lifesaver.

In particular, one of the medics that works in this division was hit by an IED -- one of these improvised explosive devices, and it took a good chunk of tissue off the side of his neck -- and in the process of doing that, actually severed his carotid artery. Usually you'd bleed to death in less than a minute from something like that. But an infantryman who'd had this combat lifesaver class, managed to get there with some gauze within that critical time period -- stopped that bleeding, and held it in that position. The soldier is now back with his family at Walter Reed recovering and doing just fine after getting his carotid artery severed and -- on a street corner.

MARK FINKELSTEIN: Thank you, Lieutenant Colonel.

MR. HOLT: Ben Strife (sp)?

Q Yes, sir. I'd like to -- I'm a former infantryman myself. I was just -- you know, and troops always perform a lot better when they know they're going to be taken care of. What role are you guys playing in preparing the Iraqi army to be able to provide basic medical care and more extensive medical care in-theater?

COL. WIEMANN: Yeah -- and that's a big program that's fully underway. The Level I and Level II medical facilities -- meaning battalion aid stations and the brigade level, the troop medical clinic, without an exception, are involved in training the Iraqi army as well.

The program involves bringing in Iraqi soldiers, preferably medics -- but that's not always the case, and trying to teach these basic soldier-skills to them. It doesn't quite get as in-depth as the combat lifesaver course or the medic's, but it starts out at a very -- a very good level where they are taught a lot of these lifesaving skills. They're usually done in very large groups, and the intent is to make as many of the Iraqi army familiar with basic first-aid as possible. And eventually, as the program progresses, we fully intend to get into the same level of training that we're doing with the American army.

Q And if I could just -- a quick follow-up there -- can you talk to any detail about the degree to which the Iraqi army has developed a hospital system, or do they rely on their civilian facilities?

COL. WIEMANN: When we first got here, there was a very strong tendency for them to try and use American facilities. However, our facilities are fairly limited. For instance, our CSHs are designed to stabilize trauma patients and evac them out to higher levels of care as quickly as possible, so we really don't have the holding capability to deal with rehabilitation. Since all that became fully recognized, we've been putting a lot of effort into revamping the Iraqis' medical system. There are several extremely large hospitals with full surgical capabilities, neurosurgical capabilities exist in a hospital right across the river from one of our CSHs. And they have large patient holding and inpatient wards. So the capabilities are all here. Due to some instability in the area, sometimes it's hard to obtain the care, but it's improving constantly, and we take --very few of the Iraqi casualties end up in our facilities now.

Q Okay, thank you, sir.

COL. WIEMANN: Yup.

MR. HOLT: And Tom.

Q Good morning and thank you. I was wondering how many soldiers have actually gone through the course. Do we know?

COL. WIEMANN: Well, for the 1st Cavalry Division, prior to deploying over here, probably 4,000 went through the course. The attempt was to get everybody through it, but that was a bigger bite than we could take off. Since that time, we've had several other brigades added from other divisions, and it would be -- it would be safe to say that 5 (thousand) to 6,000 soldiers within the division have had the combat lifesaver training.

Q Okay. And as a quick follow-up, do we have any metrics on just how effective it's been in the field -- I mean, you know, numbers of people saved because of the training?

COL. WIEMANN: It would be hard to say how many are due just to that training, but far less than 2 percent of critically injured soldiers are dying. It's -- like it's unprecedented that previous wars have died-of-wounds rates that low. And usually those woundeds that do die were catastrophic, dealing with massive head trauma at the scene, wounds that would have never been considered (survivable ?).

Q Thank you very much.

COL. WIEMANN: Certainly, sir.

MR. HOLT: And Charlie.

Q Just a quick question. This is Charlie Quidnunc at Whizbang. I wondered about survivability from a lot of these IEDs. It seems like there's so much shrapnel that's thrown into people. How do you deal with dirty wounds?

COL. WIEMANN: Yes, sir, that is a huge problem. Infection risks following injuries out here are very high. There are several species of bacteria that have proved very difficult to kill with antibiotics. The immediate availability of surgical facilities is what seems to be the key to that. And like I said, usually within 15 to 30 minutes, a patient has made it back to a combat surgical hospital and is IN the operating room getting his wounds cleaned. It's making an enormous amount of difference, but that is still a horrendous problem. Because of the weapons that they're using, a lot of dirt and debris ends up being forcibly contaminated into the wound, so it's very important to wash them out as quick as we can.

It is a big problem, but we seem to have a good handle on it. Current medical, pharmaceutical technology is also amazing, and the antibiotics that we have at our disposal almost always take care of the problem.

MR. HOLT: Okay. We've still got a few more minutes here. Does anybody else have any follow-up?

Q Yes, this is Strife again from (Red State ?). Without wandering too far afield here, could you just give an overview of the process from when a soldier is evacked from the battlefield, what kind of a decision is made to determine whether he stays in-country or he leaves theater or goes back to the U.S. or exactly, you know, what you -- how you manage him until he's returned to the unit?

COL. WIEMANN: Yes, sir. Generally, on the opinion of the treating medical team, if a soldier is going to be able to return to duty within 72 hours, they're not evacuated from theater. If they're estimating that later than 72 hours but within two weeks they're likely to return to duty, then they're sent out to another facility in a different local country where they're treated and then returned back to Iraq. But if it's going to obviously take more than two weeks for them to rehabilitate from their wounds, then they would be shipped back home.

Q And by "local country" you're not referring to, like, Landstuhl. You're talking something in the Gulf area?

COL. WIEMANN: Right. Yeah, it's right in this immediate area.

Q And for the patients passing back, does everyone who passes through Landstuhl end up back home, or are troops retained there and then returned to theater?

COL. WIEMANN: Occasionally a soldier that goes to Landstuhl will rehabilitate or heal faster than was expected, and some do return from Landstuhl. I think it'd be between 5 and 10 percent of people that end up in Landstuhl would return to Iraq.

Q So essentially that's a traffic stop on the way home, then?

COL. WIEMANN: Yes, sir, and a lot of stabilizing care is provided there. They're --

Q Right. I didn't mean to downplay what they're doing, but it's -- it's not like you're pooling people there. It's basically they stay in-country, they go local, or they end up being evacked home?

COL. WIEMANN: That's pretty much -- if a -- if a unit loses a soldier to evacuation out to Landstuhl, generally speaking, they're going to be going back home. We don't count on them returning to duty.

Q Thanks much.

MR. HOLT: All right. I usually don't interject questions here, but sir, I've got one question that I'm kind of curious about. What advances in technology have you seen over there that you're currently using, and what has that meant for you on the battlefield, for example, in recordkeeping and things like that?

COL. WIEMANN: The main thing which seems to be closely associated with soldier survival is just how quickly we're getting them to a trained surgeon after the injury, due to communication technologies and the complexity of our helicopters and our evacuation platforms. From point-of-injury, a call is made directly to our evacuation assets, at which time a helicopter literally picks the patient up in the field and takes them directly to a surgical hospital. And like I said it's often 30 minutes from the time of injury until the patient's in an operating room being treated by a surgeon. That would probably be the biggest piece, and just making sure that the patient remains stable and his wounds -- and his immediately life-threatening wounds are treated in that first 30 minutes or an hour or so before he gets to the surgeon is all up to his buddies in the field and the training that they've had.

MR. HOLT: All right. Thank you, sir.

Q I just have a follow-up regarding mental health issues. I wrote an item at NewsBusters a few days ago about a review that appeared in The New York Times of a PBS series called "America at a Crossroads." And The New York Times reviewer was describing a National Guard lieutenant who had returned from a tour in Iraq and seemed to be doing well. But the reviewer almost seemed puzzled by the notion that somebody could have gone through a tour of duty in Iraq and remained sort of mentally and emotionally stable, and she wrote -- and her writing is a bit odd, but she wrote, "He seems immune to any genuine tumbling of the spirit," and then she goes on to say, "It is hard to tell whether this extraordinary forbearance is a product of some deep emotional delusion or an admirable quality."

So she seems to posit the possibility that maintaining your mental stability after serving in Iraq could be a sign of deep emotional delusion. I wonder if, you know, just as a general opening, if I could invite you to talk about, you know, the mental stability of our troops and mental and emotional issues that we deal with as well.

COL. WIEMANN: Sure. That's quite a catch-22 she set up here, isn't it?

Q Yes. (Laughs.)

COL. WIEMANN: You can't be sane if you're acting sane. It's almost right back to the old book. (Laughs.) I would say that most soldiers are in the Army because they wanted to be soldiers, so we pre-select ourselves for the fact that this was our calling in life, that we are here to serve the country. And the good that's going on here is evident to everybody that's here. It doesn't get played up as much as it potentially could, but everybody has wonderful stories of the things they've had with schools being rebuilt, hospitals being rebuilt, children running up on the street playing with the soldiers. There's obviously a great deal of gratitude involved in the people, as well as the other things that are seen on the news.

And there are mental health problems. I will tell you that in the military, even when our mental health problems do go up, it's always considerably less than seen in the civilian sector as a whole. Suicide rates in the military are generally lower than at an age-adjusted rate within the civilian community. Again, it's a self-selection thing. The people that are here are here because that's what they wanted to do, for the most part.

Q Very -- very interesting point. Thank you.

MR. HOLT: Okay. Anyone else?

Q Jack, this is Ken. I'd like to chime in, if you don't mind.

MR. HOLT: Certainly.

COL. WIEMANN: Sure.

Q Sir, I was curious -- and if this isn't your area, please say so. There was just a report, I think in The New York Times as well about the public health situation in Iraq. Just -- sort of a prevalence of malnutrition and some water-borne illnesses, sanitation-based illnesses like diarrhea, I believe, malaria, and things like that. Do you have any idea what their capacity is to treat that, and does that cross into what -- your work at all?

COL. WIEMANN: Oh, absolutely, and that's a big part of what our goals are, is repairing the infrastructure of the country, to include sanitation grids, water supplies, garbage pickup. There's entire programs based around improving the sanitation of Baghdad.

As far as the actual health problems go, they're very similar to any other country that would be considered on the lower socioeconomic side. Diarrhea is an extremely common cause of death in human beings as a whole, nothing unique to Iraq. It's improving every day. It seems to be a common practice of the insurgents that they like to attack such things, because it does create such an impact. But headway is being made constantly in those areas.

Q Thank you.

COL. WIEMANN: Yes, sir.

MR. HOLT: All right. Well, if there's -- if there's no other questions, Colonel, thank you very much for your time today. And -- a very good conversation. Hopefully we can do this again soon.

COL. WIEMANN: Yup. It would be my pleasure. I appreciate it.

Thank you.

MR. HOLT: All right. Thank you, sir.

Q Thank you, sir.

COL. WIEMANN: Thank you. Take care. Bye bye.

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